UNITED STATES GOVERNMENT
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 16

Austin, Texas

THIRD COAST EMERGENCY PHYSICIANS, P.A. 1/

Employer

and Case No. 16-RC-10160

SETON THIRD COAST EMERGENCY PHYSICIANS ASSOCIATION

Petitioner

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, herein referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, herein referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding, the undersigned finds:**2/**

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.
2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein. **3/**
3. The labor organization involved claims to represent certain employees of the Employer. **4/**

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act. **5/**

5. The following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:

   INCLUDED: All physicians working at Seton and Seton Northwest Hospitals in Austin, Texas.

   EXCLUDED: All medical directors, physician assistants, nurse practitioners, office clerical employees, and all other non-physician employees.

DIRECTION OF ELECTION6/

An election by secret ballot shall be conducted by the undersigned among the employees in the unit found appropriate at the time and place set forth in the notice of election to issue subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit who are employed during the payroll period ending immediately preceding the date of the Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained the status as such during the eligibility period and their replacements. Those in the military services of the United States Government may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an

economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by Seton Third Coast Emergency Physicians Association.

LIST OF VOTERS

In order to ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties in the election should have access to a list containing the full names and addresses of all eligible voters which may be used to communicate with them. ***Excelsior Underwear, Inc.***, 156 NLRB 1236 (1966); ***NLRB v. Wyman-Gordon Company***, 394 U.S. 759 (1969); and ***North Macon Health Care Facility***, 315 NLRB 359 (1994). Accordingly, it is hereby directed that within seven (7) days of the date of this Decision, two (2) copies of an election eligibility list containing the full names and addresses of all the eligible voters shall be filed by the Employer with the undersigned, who shall make the list available to all parties to the election. In order to be timely filed, such list must be received in the NLRB Region 16 Regional Office, 819 Taylor Street, Federal Office Building, Room 8A24, Fort Worth, Texas 76102, on or before December 24, 1999. No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provision of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board,

addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570.

This request must be received by the Board in Washington by December 31, 1999.

DATED December 17, 1999, at Fort Worth, Texas.

/s/ Claude L. Witherspoon
Claude L. Witherspoon, Acting Regional Director
NLRB Region 16

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1. At the hearing, the Employer took the position that Third Coast Emergency Physicians, P.A., Third Coast Emergency Physicians - Sid Peterson, P.A., and Third Coast Emergency Physicians - Highland Lakes, P.A., was a single employer for the purposes of this proceeding and thus was collectively the proper employer of the unit employees described in the petition. The record evidence establishes that these three entities collectively constitute a single employer. ***See e.g. Alexander Bistritzky***, 323 NLRB 524 (1997). The four criteria used for determining whether one or more employers constitute a single employer are whether there is **1)** interrelation of operations; **2)** centralized control of labor relations; **3)** common ownership; and **4)** common management***. Radio Union v. Broadcast Service of Mobile***, 380 U.S. 255, 256 (1965); ***Masland Industries, Inc.***, 311 NLRB 184, 186 (1995). Not all of these criteria need to be present and a significant factor is the absence of an "arm's length relationship found among unintegrated companies***." Demart Coal Co.***, 315 NLRB 850, 851 (1994), enfd. 64 F.3d 661 (4th Cir. 1995).

   Regarding common ownership and management, Dr. John Moskow and Dr. Sam Roberts are the controlling owners of all three Third Coast entities. As holders of this controlling interest, Drs. Moskow and Roberts have contracted with hospitals to staff their emergency rooms with emergency physicians and mid-level providers such as nurse practitioners and physician assistants so that the emergency rooms at these hospitals are staffed for 24-hour coverage. Both Drs. Moskow and Roberts collectively oversee the emergency room physician staffs at the four hospitals supported by the three Third Coast entities.

   With regard to labor relations, Drs. Moskow and Roberts make all hiring, firing, and discipline-related decisions for the three entities. The same employee handbook is utilized by all three entities and Drs. Moskow and Roberts address individual employment issues at each respective hospital location on a case by case basis. There is also a common compliance plan utilized by all three entities in the form of a telephone number which is available for all employees to use to report possible violations. This

plan is used by all three entities to prevent fraud and abuse at the hospital locations. The telephone number originates from the administrative office in Austin and is the same number for all three entities. A staff representative monitors the telephone number from the Austin office on a regular basis and directs any reported violations of protocol to either Drs. Moskow or Roberts.

The administrative operations of all three Third Coast entities are significantly interrelated. There is one administrative office for all three entities that is located in Austin, Texas. Patient billing for all three entities is subcontracted out to a single corporation in Arlington, Texas named TERM Billing. One recruiter who operates out of the administrative office in Austin handles staff recruiting for all three entities. This recruiter places ads in newspapers and screens all applicants for potential employment. After the recruiter does an initial screening of applicants, one person at the Austin administrative office checks the credentials of all applicants by reviewing various State and Federal databases.

Accordingly, I find that Third Coast Emergency Physicians, Third Coast Emergency Physicians - Sid Peterson, and Third Coast Emergency Physicians - Highland Lakes, herein collectively, the Employer, constitute a single employer with respect to the employees described in the petition.

2. The Employer and the Petitioner filed briefs which were duly considered.

3. At the hearing, the Employer denied that it was engaged in interstate commerce within the meaning of the Act. The record reflects, and I find, that Third Coast Emergency Physicians, P.A., Third Coast Emergency Physicians - Sid Peterson, P.A., and Third Coast Emergency Physicians - Highland Lakes, P.A. are Texas professional associations engaged in the business of providing emergency room physicians and mid-level providers to hospital emergency rooms. The record also reflects that during the past 12 months, a representative period, Third Coast Emergency Physicians, Third Coast Emergency Physicians - Sid Peterson, P.A., and Third Coast Emergency Physicians - Highland Lakes, P.A., derived gross revenues of at least $1,000,000 and purchased and received goods worth at least $5,000 from suppliers within the State of Texas such as Office Max, which in turn obtained these goods from sources located outside the State of Texas.

4. The Employer contends that the Petitioner is not a labor organization within the meaning of Section 2(5) of the Act. The record reflects the Petitioner is an organization which admits members who are employees of the Employer and that the Petitioner exists, in part, for the purpose of collectively bargaining with the Employer on behalf of these employees concerning wages, hours, labor disputes, and other conditions of employment. Accordingly, I find that the Petitioner is a labor organization within the meaning of Section 2(5) of the Act. ***Alto Plastics Mfg. Corp.***, 136 NLRB 850, 851-852 (1962).

5. The Petitioner seeks to represent all emergency physicians who perform emergency services on behalf of the Employer at Seton Medical Center and Seton Northwest Hospital in Austin, Texas. The Employer asserts these emergency physicians are supervisors as defined by Section 2(11) of the Act and thus would not properly form an

appropriate unit for the purposes of collective bargaining. The Employer takes the position that if such physician employees are found not to be statutory supervisors, the proposed unit should include all emergency physicians who work at hospitals serviced by the Employer in Austin, Kerrville, and Burnet, Texas. The Employer also urges that all mid-level provider employees located at the above-described hospital locations be included within the proposed unit. There are approximately 20 employees in the unit sought by the Petitioner and approximately 39 employees in the unit urged by the Employer.

Under its entire network, the Employer provides emergency physicians to nine different hospitals in seven different cities. For each city or hospital system, the Employer operates as a separate entity. There are four hospital facilities and three entities involved in this proceeding. Third Coast Emergency Physicians provides emergency physicians for Seton Medical Center and Seton Northwest Hospitals in Austin, Texas. Third Coast Emergency Physicians – Highland Lakes, provides emergency physicians for Highland Lakes Hospital in Burnet, Texas. Third Coast Emergency Physicians – Sid Peterson provides emergency physicians for Sid Peterson Hospital in Kerrville, Texas. There are 20 emergency physicians and 7 mid-level providers employed by the Employer at the Austin hospital locations.

Drs. Moskow and Roberts have controlling interests in all three Third Coast corporate entities. Dr. Patrick Crocker is listed as an additional officer for Third Coast Emergency Physicians - Highland Lakes. Dr. Moskow is the Medical Director at Seton Northwest Hospital and Roberts holds the same position at Seton Medical Center. As medical director, Moskow interacts with Seton Northwest regarding any of its concerns and sits on the hospital's medical executive committee. Both Drs. Moskow and Roberts work some clinical shifts with other emergency physicians at both Austin hospitals.

The emergency physicians who work out of the hospitals in Austin and Kerrville are paid based on a percentage of their gross billings. The record reflects that the medical director can unilaterally alter their percentages at any time. The record also reflects that the percentage paid to the Austin physicians is higher than the percentage paid to the Kerrville physicians. In its brief, the Employer asserts that the percentage difference between the two hospitals is only 1.2%. Although the Employer takes the position that the parties agreed to hold the hearing open until it could substantiate its claim, the record does not reflect that the hearing was being held open for such purposes and I therefore do not rely on this evidence for the purposes of this proceeding. The physicians who work at the hospital in Burnet are paid $70 an hour. All physicians are eligible for bonuses that are determined by the medical director based on factors such as activities engaged in on behalf of the Employer, activities that have benefited a respective hospital, national committee memberships, and how profitable the Employer has been for a respective year.

Emergency physicians at all 4 locations are eligible for the same employee benefits pursuant to the same cafeteria plan offered by the Employer. The Employer also applies the same pension and disability plans to all emergency physicians. Any changes made to the pension plan by the Employer results in all emergency room physicians being

affected irrespective of their hospital location. The same insurance company is utilized by the Employer for all four hospitals for the provision of health benefits. The physicians who work at the Austin hospitals work 10-hour shifts. The physicians in Burnet and Kerrville work 12-hour shifts and sometimes 24 hour shifts on weekends.

All potential patients who seek emergency services at any of the four hospitals must first go through the main emergency room for an initial screening. In this main room, a prospective patient is examined by a nurse and sent to either the main emergency room or the minor emergency clinic, depending on the extent of the medical care required and the hospital protocols set up for the nurse to follow. In all emergency rooms, emergency physicians give medical orders to hospital staff such as nurses, clerks, and technicians regarding the medical care of patients. This staff is employed by the respective hospital, not the Employer. All mid-level providers work in minor emergency rooms separate from the main emergency room. Although not physicians, mid-level providers are required to have medical training and education. Emergency physicians interact with mid-level providers regarding issues associated with patient medical care. This interaction may include the physician reading and analyzing x-rays taken by a mid-level provider, the physician reviewing and analyzing medical charts of patients seen by mid-level providers, and/or the physician generally overseeing that the mid-level provider has provided patients with adequate medical care.

There are certain federal guidelines that a physician must follow regarding what must be included on a patient chart. Physicians review charts prepared by mid-level providers to ensure the documentation is within these federal guidelines. During a mid-level provider's six-month probationary period, emergency physicians see every patient handled by the mid-level provider. Once a mid-level provider has completed his or her probation, emergency physician contact is reduced but may still include instances of x-ray review, narcotic prescription approval, and assistance for medical situations outside their limited protocols. The record reflects that mid-level providers leave their charts with the emergency physician after they see patients and the emergency physician eventually reviews and signs them. Emergency physicians are paid a stipend for each mid-level provider chart they sign.

In order for mid-level providers to have separate prescriptive authority, the State of Texas requires each supervising physician to sign an affidavit certifying they are familiar with protocols and standing orders in use at the hospital site where the mid-level provider is located. This document holds all emergency physicians accountable for adequately supervising the care provided by a respective mid-level provider pursuant to those protocols or standing orders. Emergency physicians at hospitals in Burnet and Kerrville do not sign the prescriptive authority form for mid-level providers working out of the Austin hospitals and the Austin physicians do not sign similar forms for mid-level providers at the respective Kerrville and Burnet locations.

The record reflects that the same employee handbook is applied to all emergency physicians. The medical director may alter the handbook at any time. Regarding employee discipline, the record reflects the medical director has the sole authority to

determine employee punishment after the first and second infractions and the probationary period for any additional infractions. The record reveals that emergency physicians do not have the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline mid-level providers or other physicians.

The record reflects emergency physicians provide feedback to medical directors regarding the work performance of mid-level providers and the medical director uses that information to determine how many shifts to give the mid-level provider, what monetary rewards to give these employees, and whether to continue the mid-level provider on a part-time or full-time basis. Medical directors retain ultimate authority to hire, fire, or discipline mid-level providers and are responsible for setting their probation periods. Medical directors also have ultimate authority to extend mid-level provider probation dates.

Emergency physicians who have over six years of experience are eligible to participate on the Employer's Senior Advisory Council. The Senior Advisory Council was created to provide a forum for senior physicians to discuss issues regarding physician scheduling, hiring and retention. The Senior Advisory Council is currently comprised of nine emergency physicians and two medical directors (Moskow and Roberts). The record reflects that the Senior Advisory Council has only met three or four times in the last four years and has met only once in the past year. The record also reflects that Senior Advisory Council meeting times are subject to approval by the medical directors.

Pursuant to operation guidelines created by Dr. Moskow, two senior council physicians are encouraged to be present during employee hiring interviews. The evidence reflects that the emergency physicians who attend these interviews ask questions and fill out recommendation forms after the interviews are completed. Regarding physician evaluations, the record reflects that senior council members fill out a form with ten questions that ask senior council members to rank a physician on a scale of one to five on various patient care issues. The medical directors have final say on the evaluations based on their observations of the physician. The record also reflects that the medical directors seek input for physician evaluations from hospital staff. Regarding physician retention, the record reflects two instances where the Senior Advisory Council recommended the removal of a physician and that those physician were subsequently removed from their position by the medical director. Operation guidelines provide that the medical director will give great consideration to the Senior Advisory Council's opinion in these matters.

The record reflects that the Senior Advisory Council has formulated policy regarding patient charting and shift scheduling that has been adopted by the medical directors. The record reflects that the Senior Advisory Council recommended a charting policy in which physicians would be disciplined for not completing their charts and recommended that the night shift be split into two different shifts. All recommendations made by the Senior Advisory Council are subject to the approval of the medical directors and no actions recommended by this council can be implemented without the consent of the medical directors. Likewise, the record reflects incidents where the Senior Advisory Council

made recommendations regarding issues such as meeting times and physician pay that were not adopted by the medical directors.

Another committee upon which emergency physicians participate is the Emergency Performance Improvement Committee (EPIC). This committee is made up of Employer, HMO, and hospital representatives who review the practice patterns of emergency physicians. Data regarding medical tests ordered and medical procedures followed by emergency physicians is collected through a computerized tracking program and the data is then analyzed by the committee to determine if a particular physician has a pattern of test ordering that is different from other physicians. When necessary, feedback is given to the particular physician and the physician is instructed by the medical director to reevaluate their protocols. The record does not reflect any instances where the EPIC Committee ever formulated any policies or guidelines or that any of its emergency physician members ever made any effective recommendations regarding any of its directives. The record reflects that medical directors are also members of this committee.

The record reflects that emergency physicians at the two Austin hospitals attend the same section meetings. Section meetings typically include emergency physicians, nursing staff, and other employees who work in the emergency room. Physicians from the Burnet and Kerrville hospitals do not attend the Austin section meetings and Austin physicians do not attend the Burnet and Kerrville section meetings. The record reflects that the medical directors and two emergency physicians from Austin occasionally work at the hospitals in Burnet and Kerrville. One of the two physicians is an independent contractor who works for the Employer at Brackenridge Hospital in Austin while the other emergency physician has worked at the hospital in Burnet two or three times. The record reflects no emergency physicians from the hospitals in Kerrville and Burnet work at either of the Austin hospitals.

If an emergency physician leaves employment, the Employer provides emergency physicians at the other hospital sites first priority to fill the vacated position. The record reflects that there is an interchange of patients between Seton Medical Center and Seton Northwest Hospital and both Austin hospitals receive patients from the Burnet and Kerrville hospitals. The record reflects that the Austin hospitals are approximately 10 miles in distance from each other and the hospitals in Burnet and Kerrville are one and two hours away from these Austin hospitals, respectively.

The record reflects that during the past year, there was an emergency physician who performed scheduling duties for all emergency physicians at the two Austin hospitals. This physician obtained schedule requests from emergency physicians and accommodated as many of these requests as possible through shift allocations. The evidence reflects that the scheduler divided all of the physicians equally among the two Austin hospitals and scheduled them to work the same shifts on a rotating basis. The scheduler did not prepare the schedules for mid-level providers and was paid an extra $100 each hour worked on scheduling and, on average, worked approximately nine to ten hours a month in these duties. The Employer has recently hired an employee in its administrative office to handle physician scheduling for the two Austin hospitals.

Supervisory Status of Emergency Physicians

The burden of proving that a certain individual is a supervisor rests squarely on the party asserting that such a status exists. ***Vencor Hospital-Los Angeles***, 328 NLRB No. 167 (1999); ***Youville Heath Care Center, Inc.***, 327 NLRB No. 52 (1998). In ***NLRB v. Health Care & Retirement Corp.***, 511 U.S. 571 (1994), the Supreme Court held that the Board must apply the statutory criteria set forth in Section 2(11) of the Act in the health care field in the same manner as any other industry. The Supreme Court noted that in making a determination on the question of one's supervisory status, the statute requires that three criteria be met: **(1)** the employee has the authority to engage in one of the 12 listed activities in Section 2(11) of the Act; **(2)** the employee exercises that authority using independent judgment; and **(3)** the employee holds authority in the interest of the employer. ***Health Care Retirement Corp***, 511 U.S. at 573-574.

Record evidence is clear that these emergency physicians do not have the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline mid-level providers. In its brief, the Employer argues emergency physicians responsibly direct mid-level providers regarding compliance with hospital protocols, standing orders, and federal requirements regarding the preparation of patient charts. Notwithstanding these arguments, it is well established that restrictions imposed by government regulations do not constitute actual control or supervision by a putative employer. ***See, e.g., Air Transit, Inc.***, 271 NLRB 1108 (1984). The evidence reflects that emergency physicians at a respective hospital sign an affidavit pursuant to Texas law that they are responsible for making sure mid-level providers follow hospital protocols and standing orders. Such mandated accountability by the State of Texas does not establish emergency physicians are supervisors. Similarly, the fact emergency physicians are responsible for overseeing that federal requirements are met in patient chart preparation does not establish their supervisory status.

The evidence reflects that emergency physicians interact with mid-level providers on a routine basis. This interaction includes emergency physicians reviewing patient charts, analyzing x-rays, and generally overseeing that the mid-level provider has provided a patient with adequate medical care. When professionals such as emergency physicians give directions to other employees, those directions do not make those professionals supervisors merely because these professionals used independent judgment in deciding what instructions to give. ***Providence Hospital***, 320 NLRB 717, 728 (1996). Such professional direction does not grant emergency physicians supervisory status. ***Providence Hospital***, 320 NLRB at 728.

The record demonstrates that interaction between emergency physicians and mid-level providers is limited to the physicians relaying their medical opinions to mid-level providers regarding patient care. The record is devoid of evidence demonstrating that emergency physicians direct mid-level providers regarding their terms and conditions of employment or that they exercise any independent judgment regarding such employment issues. There is no evidence in the record demonstrating that emergency physicians

responsibly direct mid-level providers regarding their work schedules, their break and lunch schedules, their office location, or their pay and benefits or exercise any independent judgment regarding any of these employment areas. ***See, e.g. Nymed, Inc.***, 320 NLRB 806, 810-811 (1996); ***North General Hospital***, 314 NLRB 14, 17-18 (1994).

In its brief, the Employer references an incident in which emergency physicians made a recommendation to the medical directors that a particular mid-level provider's probationary period be extended past six months and an incident where emergency physicians recommended not using another mid-level provider past their respective probationary period. The record reflects, however, that the medical directors, not the emergency physicians, set the dates for probationary periods and that medical directors, not emergency physicians exercise unilateral authority to extend these dates. More importantly, there is no record evidence regarding any details associated with any employee probation or what role the recommendations served in the ultimate decisions made by the medical director.

In its brief, the Employer also references instances where emergency physicians have provided written feedback to the medical directors regarding mid-level providers acting on their own accord. There is no evidence in the record documenting any of these occurrences or establishing that emergency physicians have effectively recommended any particular action be taken in conjunction with these occurrences. ***North General Hospital***, 314 NLRB at 17-18. Likewise, the record does not show that emergency physicians have the authority to effectively recommend any action be taken against a mid-level provider for engaging in such conduct. Record evidence demonstrates that such potential disciplinary action remains within the purview of the medical directors and their sole authority to enforce employee handbook policies.

Based on the totality of the evidence, I find that the Employer has failed to show that emergency physicians exercise independent judgment with regard to any of the factors establishing supervisory status under Section 2(11) of the Act, and, as such, I find that these employees are properly included in the appropriate unit.

Supervisory Status of Senior Advisory Council members

The Employer contends that emergency physicians who are members of the Employer's Senior Advisory Council are supervisors because these employees formulate policies and make effective recommendations to management regarding physician hiring, firing, and retention. The record does not establish, however, that these senior physicians exercise any supervisory authority. First and foremost, record evidence reveals that membership and participation on the Senior Advisory Council does not grant emergency physicians the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline mid-level providers or physicians.

In its brief, the Employer argues that senior council members make effective recommendations regarding new physicians hires. Aside from record evidence that senior physicians fill out recommendation forms which assist the medical director in

ranking interviewees, there is no evidence regarding what role, if any, these recommendations play in the medical director's ultimate decision to hire or not hire a particular candidate. Likewise, the Employer contends that senior council members vote on whether new physicians should be hired and that the medical director relies on these recommendations. There is no evidence, however, detailing specific instances of where and when this vote has occurred or what role the vote played in the medical director's ultimate decision to hire or not hire an applicant. Mere participation in the hiring process, absent the authority to effective recommend hire, is insufficient to establish Section 2(11) supervisory authority, ***North General Hospital***, 314 NLRB at 16, particularly in light of the fact medical directors retain final decision-making authority associated with any and all employment hiring.

The record references two instances where the Senior Advisory Council recommended that a physician be removed from employment. Notwithstanding these recommendations, the Senior Advisory Council Operation Guidelines provide that great consideration will be given to senior council members' opinions on physician retention but that the medical directors retain final authority regarding whether a physician is to be retained or not. The retention of such final authority by the medical directors demonstrates that senior council members do not make effective recommendations. ***North General Hospital***, 314 NLRB at 17-18. Additionally, the record is devoid of evidence documenting the details associated with the removals or what role the recommendation had with regard to the medical director's ultimate decision to remove the physician from employment.

In its brief, the Employer also asserts that senior physicians make effective recommendations regarding physician evaluations. The evidence shows, however, that the medical director has final say on the evaluations based on his observations of the physician. The record also reflects that the medical directors seek input regarding physician evaluations from the hospital staff who works with the physician. The Board has held that effective recommendation generally means that recommended action is taken without independent investigation by superiors, not simply that the recommendation is ultimately followed. ***Children's Farm Home***, 324 NLRB 61 (1997). The evidence demonstrates that the medical director still conducts and participates in all physician evaluations and that they solicit feedback from sources other than senior council members.

At the hearing, the Employer provided evidence purported to be examples of the Senior Advisory Council formulating policy that was adopted regarding patient charting and shift scheduling. The record reflects that the council recommended a charting policy in which physicians would be disciplined for not completing their charts. The council also recommended the splitting of the night shift. Notwithstanding these two incidents, the record is clear that all recommendations made by the Senior Advisory Council are subject to the approval of the medical directors and that no actions recommended by this council can be implemented without the consent of the medical directors. The record also reflects incidents where the Senior Advisory Council made recommendations regarding other employment issues such as meeting times and physician pay but these recommendations were not adopted by the medical directors. Again, the retention and

exercise of decision-making authority by the medical directors demonstrates that senior council members do not make effective recommendations. ***North General Hospital***, 314 NLRB at 17-18.

Based on the totality of the evidence, I find that the Employer had failed to show that emergency physicians on the Senior Advisory Council exercise independent judgment with regard to any of the factors establishing supervisory status under Section 2(11) of the Act and, as such, I find that these employees are properly included in the appropriate unit.

Managerial Status of Senior Advisory Council and EPIC Committee Physicians

Managerial employees are defined as those employees who "formulate and effectuate management policies by expressing and making operative decisions of their employer." ***NLRB v. Yeshiva University***, 100 U.S. 672, 682-683 (1980). Managerial employees must be aligned with management and must exercise discretion within, or independently of, established employer policy. ***NLRB v. Yeshiva University***, 100 U.S. at 682-683. The record reveals that although Senior Council members have discussed employment policy and made recommendations to management in areas associated with patient charting, work shifts, and physician retention, all recommendations made by these physicians are subject to approval by the medical directors. No actions recommended by the Senior Advisory Council can be implemented without the consent of the medical directors.

In its brief, the Employer argues that emergency physicians who participate on behalf of the Employer on the EPIC Committee are managers as defined by the Act. There is no record evidence, however, reflecting any instances where the EPIC Committee formulated any policies or guidelines on behalf of the Employer or that any of its emergency physician members ever made any effective recommendations regarding such directives. As such, the evidence is clear that emergency physicians on the Senior Advisory Council and the EPIC Committee do not formulate and effectuate management policies of the Employer independent of established Employer policies. Accordingly, I find the senior employees who participate on either the Senior Advisory Council or the EPIC Committee are not managers under the Act and are properly included in the appropriate unit. ***See, e.g., Montefiore Hospital and Medical Center***, 261 NLRB 569 (1982).

Supervisory Status of the Scheduler

The employer contends that the emergency physician who has scheduling duties for the two Austin hospitals exercises independent judgment and discretion in performing these duties and is thus a supervisor as defined by Section 2(11) of the Act. Notwithstanding this assertion, the record reflects the Employer has replaced this emergency physician with an employee at its administrative office and that this administrative employee, not the emergency physician, handles physician scheduling for the two Austin hospitals. Even if the emergency physician was continuing to perform these scheduling duties, the evidence does not support finding these scheduling responsibilities equate to the scheduler possessing any supervisory indicia.

The evidence shows that the scheduler essentially obtains specific schedule requests from emergency physicians and then tries to accommodate all of these requests through equitable shift allocations. The evidence further reflects that physicians are equally divided among the two Austin hospitals and work the same shifts on a rotational basis. Balancing work assignments among physicians or using other equitable methods does not require the exercise of supervisory independent judgment. ***Providence Hospital***, 320 NLRB at 732; ***Ohio Masonic Home***, 295 NLRB 390, 395 (1989). Such assignments are considered routine assignments. ***Providence Hospital***, 320 NLRB at 727; ***Ohio Masonic Home***, 295 NLRB at 395.

Accordingly, the record evidence demonstrates that the employee who performs the duties of a scheduler does not exercise supervisory independent judgment and, as such, I find the employee who performs these duties is not a supervisor under the Act and is properly included in the appropriate unit.

Scope of Emergency Physician Unit

Emergency Physicians in Austin, Kerrville and Burnet, Texas

While the Board typically applies a presumption in favor of finding single-facility units in health care institutions to be appropriate, this presumption may be overcome by factors which militate against its appropriateness. ***Lutheran Welfare Services of Northeastern Pa.***, 319 NLRB 886 (1995); ***West Jersey Health System***, 293 NLRB 749, 751 (1989). In considering whether the presumption of appropriateness has been rebutted, the Board considers whether the locations at issue have: **(1)** centralized control over daily operations and labor relations; **(2)** employees with common skills and functions; **(3)** common benefits and wage scales; **(4)** common personnel policies; **(5)** common administration and financial services; **(6)** common handbooks; **(7)** common vacancy postings; **(8)** functional integration; and **(9)** employee interchange. ***Lutheran Welfare Services of Northeastern Pa.***, 319 NLRB at 886; ***West Jersey Health System***, 293 NLRB 749, 751 (1989). The Board also considers proximity of multiple locations in its analysis. ***West Jersey Health System***, 293 NLRB at 749.

The Petitioner seeks to represent a unit consisting of Austin emergency physicians. The Employer seeks the inclusion of emergency physicians who also work at hospitals in Burnet and Kerrville. Critical to the determination regarding the physician employees at these two Austin hospitals were factors such as common skills and functions, common benefit and compensation plans, common handbooks, proximity of the two hospitals, functional integration and employee interchange. The record reveals that the physicians who work at both Austin hospitals provide the same emergency services for each hospital's respective emergency room including but not limited to patient medical care and patient chart review. In addition to being subject to the same employment policies, the evidence shows these physicians also share the same compensation rates and the same health, pension, and disability benefits.

The evidence shows that the Austin hospitals are only ten miles apart and are thus in close proximity to each other. Regarding employee interchange, the evidence reveals that the Austin physicians work at both Austin hospitals and work the same shifts on a rotational basis. The Austin physicians are scheduled in such a way so that half of the physicians cover shifts at Seton Medical Center and half cover shifts at Seton Northwest. As a result of covering shifts at both Austin hospitals, the evidence reveals the physicians at both hospitals interact with the same mid-level providers and the same hospital staffs on a daily basis. Additionally, the Austin physicians attend the same section meetings.

As emergency physicians, Austin, Burnet and Kerrville physicians provide very similar emergency services for their respective emergency rooms. Likewise, all of these physicians are subject to the same employment policies. The evidence reveals, however, that Austin physicians are under a different compensation plan than the physicians in Burnet and Kerrville. Additionally, the evidence shows that the Austin physicians are scheduled to work different shifts than their counterparts in Burnet and Kerrville. The emergency room staffs at the Austin hospitals are also different from the ones in Burnet and Kerrville. The evidence shows that there are only full-time physicians in Austin. The evidence shows there are both full and part-time physicians working in Burnet and Kerrville.

The record shows that the physicians in Austin and the physicians in Burnet and Kerrville do not interact on a daily basis. Playing a part in this lack of interaction is evidence the Austin hospitals are close in proximity to each other whereas the Burnet and Kerrville hospitals are approximately one to two hours away from these Austin hospitals, respectively. This lack of interaction is also reflected by the fact that the Austin physicians do not work in Burnet and Kerrville and the physicians in Burnet and Kerrville do not work in Austin. The Employer asserts that there are physicians from Austin who work at the Burnet and Kerrville hospitals but the evidence reveals that other than the medical directors and independent contractors referenced above, only one physician from Austin has worked at the hospital in Burnet on two or three occasions.

While the performance of similar tasks might be the basis for finding a broader unit appropriate, if sought, it is the Employer who must establish that the petitioned-for narrower unit is inappropriate. ***Executive Resource Associates, Inc.***, 301 NLRB 400, 402 (1991); ***Omni-Dunfey Hotels, Inc.***, supra. The Act, however, allows a union to petition for a appropriate unit, and does not require it seek the most appropriate unit, even when a different than petitioned-for unit might be more appropriate. ***Morand Bros. Beverage Co.***, 91 NLRB 409 (1950), enfd. 190 F.2d 576 (7th Cir. 1951); ***Omni-Dunfey Hotels, Inc.***, 283 NLRB 475 (1987); ***Federal Electric Corp***, 157 NLRB 1130, 1132 (1966); ***Capital Bakers***, 168 NLRB 904, 905 (1967).

Based on the above and the record as a whole, I find there is a sufficient community of interest to require the inclusion of emergency physicians from the two hospitals located in Austin, Texas into the unit sought by the Petitioner. I do not find, however, that there is a sufficient community of interest to require that the emergency physicians located at hospitals in Kerrville and Burnet, Texas be included in this unit. Although the evidence

reflects all emergency physicians perform similar functions and are subject to similar employment policies, this consideration does not outweigh the evidence that the Austin physicians and Kerrville and Burnet physicians lack common compensation plans and work areas, employee interchange, functional integration, or the evidence that the Kerrville and Burnet hospitals are a significant distance from the Austin hospitals. Accordingly, only emergency physicians working at the hospitals in Austin will be included in the unit found appropriate herein.

Nurse Practitioners and Physician Assistants

When dealing with acute care hospitals, the Board has found only eight bargaining units to be appropriate. ***Boston Medical Center Corp.***, 330 NLRB No. 30, slip op. at 15 (1999). These bargaining units include **(1)** all registered nurses; **(2)** all physicians; **(3)** all professionals except registered nurses and physicians; **(4)** all technical employees; **(5)** all skilled maintenance employees; **(6)** all business office clerical employees; **(7)** all guards; and **(8)** all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. ***Boston Medical Center Corp.***, 330 NLRB slip op. at 15; 54 Fed Reg. 16336 (April 21, 1989), reprinted at 284 NLRB 1580.

The record demonstrates that although physician assistants and nurse practitioners routinely interact and work with physicians on a daily basis, including these employees with the physicians would not comport with the Board's Rule regarding appropriate health care units. The Health Care Rule explicitly permits representation elections in nonconforming units, however, when the parties have stipulated to such a unit or the petition is for an additional unit in the face of an already existing nonconforming unit. ***Boston Medical Center Corp.***, 330 NLRB slip op. at 17. Neither situation is present in the instant matter. More importantly, no evidence has been provided demonstrating that there are "extraordinary circumstances" warranting the proliferation of the health care industry units defined by the Board's rulemaking. ***See, e.g., Boston Medical Center Corp.***, 330 NLRB slip op. at 17; ***The Child's Hospital, Samaritan Service Corp.***, 310 NLRB 560, 562 (1993). Accordingly, I find that nurse practitioners and physician assistants are not properly included in the petition-for unit.

6. In accordance with Section 102.67 of the Board's Rules and Regulations, as amended, all parties are specifically advised that the Regional Director will conduct the election when scheduled, even if a request for review is filed, unless the Board expressly directs otherwise.

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